

ARTICLE 4. RECORDS AND PUBLIC INFORMATION

Section 1340. Reporting of Legal Actions.

Each facility shall submit to the Board of Corrections a letter of notification on each legal action, pertaining to conditions of confinement, filed against persons or legal entities responsible for juvenile facility operation.

Guideline: Administrators must notify the Board of Corrections of any legal action in state or federal courts pertaining to conditions of confinement. This allows the Board to monitor conditions in the facility, provide technical assistance if requested, and stay informed about significant legal issues that are facing juvenile facilities throughout the state.

Section 1341. Death and Serious Illness or Injury of a Minor While Detained.

(a) Death of a Minor

In any case in which a minor dies while detained in a juvenile facility, jail, lockup or court holding facility:

(1) The administrator of the facility shall provide to the Board of Corrections a copy of the report submitted to the Attorney General under Government Code Section 12525. A copy of the report shall be submitted to the Board within 10 calendar days after the death.

(2) Upon receipt of a report of death of a minor from the administrator, the Board may within 30 calendar days inspect and evaluate the juvenile facility, jail, lockup or court holding facility pursuant to the provisions of this subchapter. Any inquiry made by the Board shall be limited to the standards and requirements set forth in these regulations.

(3) The health administrator, in cooperation with the facility administrator, shall develop written policy and procedures to assure that there is a medical and operational review of every in-custody death of a minor. The review team shall include the facility administrator and/or the facility manager, the health administrator, the responsible physician and other health care and supervision staff who are relevant to the incident.

(b) Instructions for notification

The facility administrator shall develop written instructions for handling deaths, suicide attempts, suicide prevention and for notification of the Juvenile Court and the parent, guardian, or person standing in loco parentis, in the event of a serious illness, injury or death of a minor.

Guideline: Policies and procedures are required for responding to the death, serious illness or injury of a minor. These policies must define the illnesses and injuries that are included and establish procedures to notify the individuals identified in the regulation. For security reasons, probation staff will typically have the lead in making this notification. For example, when a high risk minor is transported from the facility for emergency care, it is important that the timing of family notification not alert others in the community who might facilitate an escape or threaten

the safety of the minor and/or transporting staff. Health care staff should provide supporting information on clinical conditions.

Government Code Section 12525 requires all detention facilities to submit a "death in custody report" to the Attorney General, California Department of Justice (DOJ) within ten (10) days of the death. There is a specific DOJ form for reporting these deaths that is available from them. The DOJ procedures require that the department attach the incident report describing the events surrounding the death. This regulation requires that a copy of the information going to the Department of Justice also be forwarded to the Board of Corrections within the 10-day timeframe.

Documenting a minor's death and the conditions surrounding it provides assistance to staff and administrators who may be called to testify about an incident months or years after it occurred. It also provides information about conditions in a facility and may indicate where staff needs additional training or where procedures are not serving the purpose for which they were designed.

There are several kinds of reviews that are triggered by a death in custody. While this standard calls for a medical review, there is also an immediate review for the purpose of determining the most likely cause of death, the circumstances surrounding it, factors which may have contributed to it and what emergency procedures might need to be implemented. It is necessary to ask these questions about every death. Even in cases of death by natural causes, sick call or other routine procedures may need closer scrutiny or modification (i.e., had the minor complained about something in the past, how had the complaint been handled, etc.).

The medical review is a thorough assessment of the conditions surrounding a minor's death. The purpose is to alert the medical delivery system to any weaknesses or failures on its part that may have lead to the death or failed to prevent it. Thus, it is an additional quality control of the facility medical service. This review should be performed after all autopsy and other reports have been received, which could take more time than anticipated, especially if a criminal investigation is being conducted. Nonetheless, the medical review will be inadequate if conducted too soon; it must be a final review and must be able to incorporate all previous reports and relevant information.

Typically, the review team should include health care and custody staff that are relevant to the incident, as well as the facility manager, health administrator and responsible physician. Administrators and managers need to be aware of what is occurring in their facility and should either participate directly or designate staff to participate as their representatives, as in any other kind of investigation.

All circumstances surrounding the death should be evaluated from a medical perspective. The review may also identify areas where the integration of custody and medical policies needs improvement. Did medical personnel see the minor prior to his/her death? What was the minor's complaint? What was charted, if anything, on the medical record or in the custody log? What does the coroner's report indicate as the cause of death? Were there any time delays in seeking

medical or mental health assistance for the minor? All information relative to the death gathered by medical or custody staff should be reviewed.

County counsel should be consulted when developing review committee responsibilities, obligations, immunities, and authority. This is to ensure the protection of review committee members, the probation department, and the county. Documentation of these reviews should not be taken lightly. The documents are "discoverable" during litigation, and counsel may recommend limiting the review to oral reports, with documentation noting only that the committee met.

Section 1342. Population Accounting.

Each juvenile facility shall submit monthly population and profile survey reports to the Board of Corrections within 10 working days after the end of each month, in a format to be provided by the Board.

Guideline: This regulation requires facilities to submit monthly population data to the Board of Corrections within 10 working days of the end of each month. There is a prescribed reporting format that enables the Board to develop statewide data on juvenile facility populations. This information is used to respond to questions from state and local administrators, the legislature, media and other inquiries. The information is valuable in determining and supporting funding needs for construction and renovation.

Section 1343. Juvenile Facility Capacity.

The Board of Corrections shall establish the maximum capacity of a juvenile facility based on statute and applicable regulations. When the number of minors detained in a living unit of a juvenile facility exceeds its maximum capacity for more than fifteen (15) calendar days in a month, the facility administrator shall provide a crowding report to the Board in a format provided by the Board. The Executive Director of the Board of Corrections shall review the juvenile facility's report and initiate a process to make a preliminary determination if the facility is suitable for the continued confinement of minors. If the Executive Director determines that the facility is unsuitable for the confinement of minors, the recommendation shall be reviewed by the Board of Corrections at the next scheduled meeting. Notice of the Board's findings and/or actions shall be public record and, at a minimum, will be provided to the facility administrator, presiding juvenile court judge, chairperson of the board of supervisors and juvenile justice commission within ten working days of the Board meeting.

Guideline: This regulation requires departments to report unit crowding of 15 days or more to the Board of Corrections. Crowding is identified as exceeding the established "maximum capacity" of the housing area (**Section 1302, Definitions**). Reporting is done through "Crowding Assessment Reports" (CAR) and, when crowding persists for more than three months, a "Comprehensive Crowding Assessment Report" (CCAR) must be submitted. The Board

monitors these report and works directly with individual departments to develop a suitability plan. In most instances, these plans successful mitigate the impact of crowding. When this cannot be done at the staff level, there is provision to report to the appointed members of the Board of Corrections, with the potential of the Board identifying the facility as "unsuitable" to hold minors.